MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11167

CERTIFICATE OF DEATH

11154
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 19 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4
d. STREET ADDRESS: 1655 E. Cold Spring Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wayne — Middle: Elbert — Last: Batton

4. DATE OF DEATH: Month: October — Day: 16 — Year: 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: June 30, 1920

9. AGE (In years last birthday): 38 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steel Worker

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: (Fleming) Fielding Batton

14. MOTHER'S MAIDEN NAME: (Blanche) Margaret Zervy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: 233-12-7177

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Laennec's cirrhosis. — INTERVAL BETWEEN ONSET AND DEATH: month
581.1
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ABS associated with alcoholism plus CBS associated with alcoholism

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour: o. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 27, 19 58, to October 16, 19 58, that I last saw the deceased alive on October 16, 19 58, and that death occurred at 11:50 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo. M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 10/16/58

PHYSICIAN'S NAME (Type): Agustin delCampo, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/19/58

22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Cem.

22d. LOCATION (City, town, or county) (State): West Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Leonard T. Rueck 5305 Hamford Rd

24a. REC'D BY REGISTRAR — DATE: OCT 20 '58

24b. REGISTRAR'S SIGNATURE: Clifton S. Kinnard

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11155

11168

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester #1
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester #1
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Clinton Middle H. Last Baughman

4. DATE OF DEATH Month October Day 26 Year 1958

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 5/9/1882
9. AGE (In years last birthday) 76 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (State or foreign country) Carroll Co Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George Baughman
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 213-18-8604
17. INFORMANT Address Carl C. Baughman Manchester #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days
331 X
DUE TO (b) Hypertension — 5 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 4, 19 58, to Oct 26, 19 58, that I last saw the deceased alive on Oct 25, 1958, and that death occurred at 3 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE W H Foard M.D.
ADDRESS (Street, city or town, state) Manchester Md
DATE SIGNED 10-27-58
PHYSICIAN'S NAME (Type) W. H. Foard. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10/29/58
22c. NAME OF CEMETERY OR CREMATORY St Marks Lutheran
22d. LOCATION (City, town, or county) (State) Hanover Pa RD York Co.

23. FUNERAL DIRECTOR'S SIGNATURE Frederick Bucher
ADDRESS Hanover Pa
24a. REC'D BY REGISTRAR DATE OCT 28 '58
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11169

CERTIFICATE OF DEATH

Reg. Dist. No. 11156

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Union Mills
c. LENGTH OF STAY IN 1b: 9 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Meadow View Convelescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 27 Westminster
d. STREET ADDRESS: 173 W. Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Effie — Middle: Elizabeth — Last: Belt

4. DATE OF DEATH: Month: October — Day: 15, — Year: 19 58

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: November 20, 1869

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles M. Hess

14. MOTHER'S MAIDEN NAME: Elizabeth Bushey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Mrs. M. Ross Fair, Taneytown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.

DUE TO (b): Chronic Nephritis (Glomerulitis) — 6 years

DUE TO (c): Chronic Nephrosclerosis — 8 years

4222

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/1 19 58 to 10/15 19 58 that I last saw the deceased alive on 10/15 19 58, and that death occurred at 5 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Luther Bare M.D. — ADDRESS (Street, city or town, state): Westminster Md. — DATE SIGNED: 10/17/58

PHYSICIAN'S NAME (Type): Dr. LUTHER BARE

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 18, 1958

22c. NAME OF CEMETERY OR CREMATORY: Lutheran Cemetery

22d. LOCATION (City, town, or county) (State): Taneytown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Merwyn C. Fuss — ADDRESS: C.O.Fuss & Son, Taneytown, Maryland

24a. REC'D BY REGISTRAR DATE: OCT 20 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11170 — Reg. Dist. No. 11157

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 mo. 29 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 28 — 0352.2
d. STREET ADDRESS: 3 N. Beechwood Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Sarah — Middle Elizabeth — Last Blacklock
4. DATE OF DEATH: Month October — Day 24, — Year 19 58
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 18, 1872
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Missionary
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Allan R. Blacklock
14. MOTHER'S MAIDEN NAME: Jane Chambers
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: 215-32-6456
17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerosis heart disease — INTERVAL BETWEEN ONSET AND DEATH: years
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 25, 19 58, to October 24, 19 58, that I last saw the deceased alive on October 24, 19 58, and that death occurred at 2:00a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 10/24/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1-27-58
22c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Farley Fun. Home — ADDRESS: Frederick Rd. & Shady Rock Ave. Catonsville, 28, Md.
24a. REC'D BY REGISTRAR DATE: OCT 31 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

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M

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11171

CERTIFICATE OF DEATH

11158

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland — b. COUNTY: City
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville — c. LENGTH OF STAY IN 1b: 1y 2 m 9 d	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 18, Md. 3V01-4
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital	d. STREET ADDRESS: 2714 Guilford Avenue — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Archie	Nataniel	Bowen	10	3	1958

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		2-18-98	60 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
unkn	Seaman	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Arthur Bowen	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	unkn	S.S. Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: years

422.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. assoc.with circulatpry disturbance with cerebral arterioscler. with psych.reaction.Pulm.Tuberculosis mod.advanced,inactive — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
	002X

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-24-, 1958, to 10-3-, 1958, that I last saw the deceased alive on 10-3-, 1958, and that death occurred at 11:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lustbaus M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 10-4-58

PHYSICIAN'S NAME (Type): Edmund Lustbaus M.D. — Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	10/7/58	Cedar Hill	Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
JOHN F. DENNY, INC. 715 Light St. Baltimore-30, Md.	OCT 8 '58	Arthur L. Kraus

18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11172 **CERTIFICATE OF DEATH** 11159 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 91 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harwood Route 2, P.O. 02K-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: Alexander — Last: Butler

4. DATE OF DEATH: Month: October — Day: 1 — Year: 19 58

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-18-06

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Butler

14. MOTHER'S MAIDEN NAME: Maggie Savoy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 213-004-0574

17. INFORMANT: William A. Butler — Address: Route #2, P.O. Anne Arundel Harwood, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiovascular insufficiency — INTERVAL BETWEEN ONSET AND DEATH

002X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Far advanced bilateral cavitary pulmonary Tbc.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 2, 19 58, to October 1, 19 58, that I last saw the deceased alive on October 1, 19 58, and that death occurred at 8:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E. M. Maculans M.D. — ADDRESS (Street, city or town, state): Henryton, Maryland — DATE SIGNED: 10-1-58

PHYSICIAN'S NAME (Type): Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 10-8-58 — 22c. NAME OF CEMETERY OR CREMATORY: Evans Chapel — 22d. LOCATION (City, town, or county) (State): A.A. Co., MD

23. FUNERAL DIRECTOR'S SIGNATURE: M M Reese — ADDRESS: Annapolis, Md

24a. REC'D BY REGISTRAR DATE: 10-1-58 OCT 7 '58 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Kunes

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11160

11173

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
8M 2/57

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 5yrs. 2mos. 14days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5609 Roosevelt St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Jane Middle Baird Last Patterson CARNESECCHI
4. DATE OF DEATH: Month October Day 16, Year 1958
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: February 1, 1881
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Scotland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Patterson
14. MOTHER'S MAIDEN NAME: Agnes Muir

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Springfield Hospital Records
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes
420.1
DUE TO (b): Coronary arteriosclerosis — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. assoc. with circ. dist. with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10/17/58
EXAMINER'S NAME (Type): James T. Marsh, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 10/20/58
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS: Robert A. Pumphrey-Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: OCT 20 '58
24b. REGISTRAR'S SIGNATURE: Clinton L. Evans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11161 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11161

Item 9 Film G235 11-3-58 et

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

1. PLACE OF DEATH
a. COUNTY: CARROLL COUNTY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 25 HRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
d. STREET ADDRESS: #10 WILLOW AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First HARRY Middle MONTROSE Last CHEW

4. DATE OF DEATH: Month 10 Day 21 Year 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: april 1, 1901

9. AGE (In years last birthday): 57 5/8 yrs.

IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WESTERN MARYLAND RAILROAD EMPLOYEE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): FINKSBURG MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES CHEW

14. MOTHER'S MAIDEN NAME: FANNY B. CHEW nee ??

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): WWI SEPT. 1917 - SEPT. 1918

16. SOCIAL SECURITY NO.: 216-03-2978

17. INFORMANT Address: WIFE — MRS. MARY L. CHEW

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Crushed Chest + Internal Injuries — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

816 x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Ran into Car into Rear end of Tractor Trailer

20c. TIME OF INJURY: Hour 8 p. m. Month, Day, Year 10/21 1958

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): US Route 140

20f. (City or town) Westminster (County) Carroll (State) md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. Glenn Speicher M.D.

EXAMINER'S NAME (Type): acting

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 10/21/58

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10/25/58

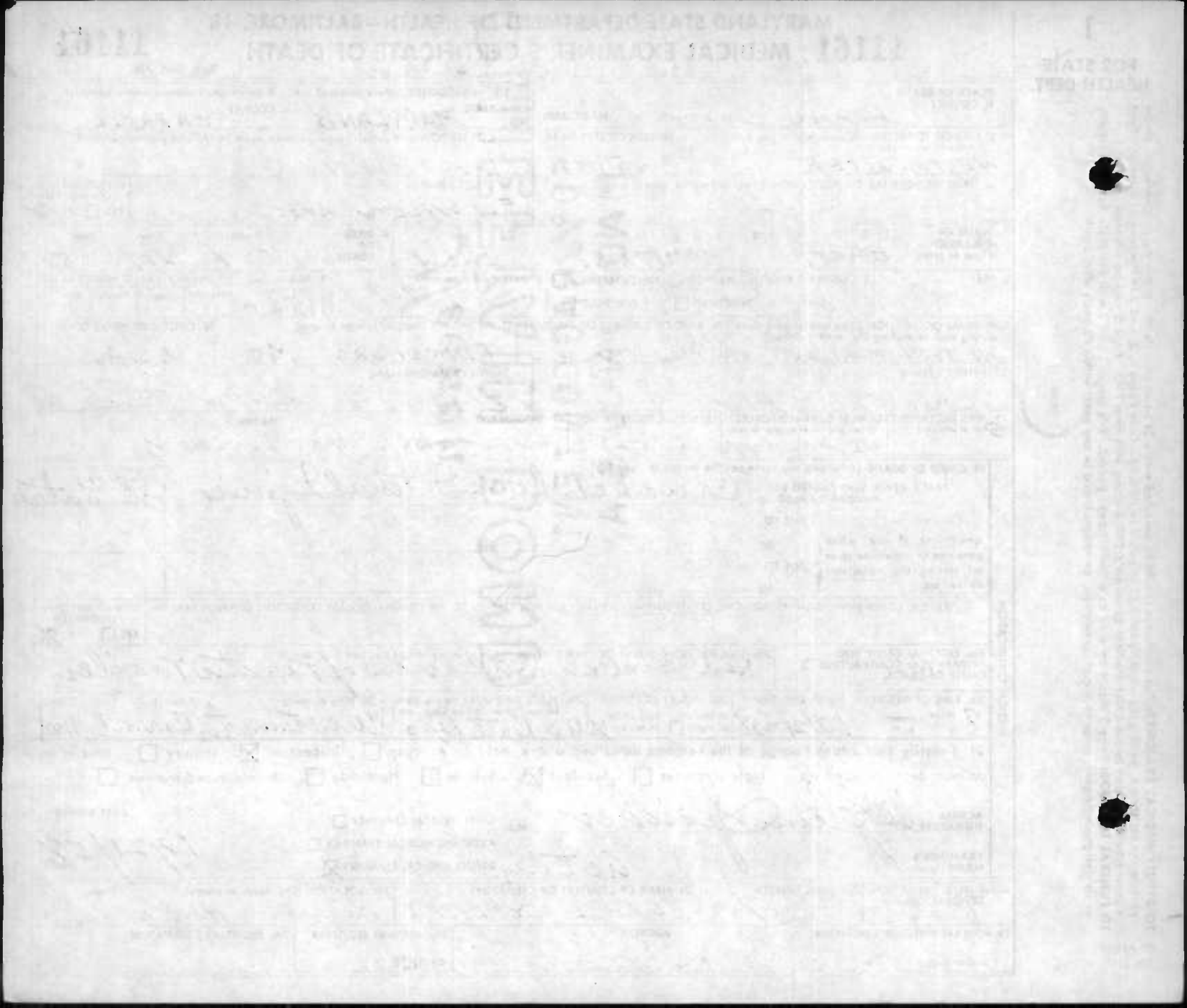
22c. NAME OF CEMETERY OR CREMATORY: BETHEL CEMETERY

22d. LOCATION (City, town, or county) (State): REESE MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: James G. Saffell Jr. ADDRESS 254 E main St. Westminster Md

24a. REC'D BY REGISTRAR DATE OCT 24 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Haus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11162

CERTIFICATE OF DEATH

11162 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY CARROLL Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER
c. LENGTH OF STAY IN 1b 80 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 204 Penna. Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER
d. STREET ADDRESS 204 Penna. Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First JESSE Middle FRANCIS Last CHREST

4. DATE OF DEATH Month OCT. Day 18 Year 1958

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Feb. 15 1878
9. AGE (In years last birthday) 80 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BLACKSMITH, Self employed
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) WESTMINSTER, md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME GEORGE A. CHREST
14. MOTHER'S MAIDEN NAME MARGARET J. FOWLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT MISS LILLIAN L. CHREST Address (204 PENNA AVE.) WESTMINSTER MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage
331X
DUE TO (b) Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 1 week

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1948, to Oct 18-58, 19, that I last saw the deceased alive on Oct 18-58, 19, and that death occurred at 5:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Wm C Jeanette M.D. ADDRESS (Street, city or town, state) 103 E Main Westminster Md DATE SIGNED 10-20-58

PHYSICIAN'S NAME (Type) Wm Carl Jeanette M.D. Westminster, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF OCT. 22, 58
22c. NAME OF CEMETERY OR CREMATORY LEISTER'S CEMETERY
22d. LOCATION (City, town, or county) (State) RURAL, WESTMINSTER, MD.

23. FUNERAL DIRECTOR'S SIGNATURE J. S. Myers Jr. ADDRESS Westminster, Md.
24a. REC'D BY REGISTRAR DATE OCT 22 '58
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11174 **CERTIFICATE OF DEATH** 11163

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester
c. LENGTH OF STAY IN 1b 2yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Longview Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Frodrick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg
d. STREET ADDRESS East Main
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Edwin Middle Lost Chrisner

4. DATE OF DEATH Month October Day 9 Year 1958

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Nov. 6, 1866.
9. AGE (In years last birthday) 91 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wheelwright
10b. KIND OF BUSINESS OR INDUSTRY Carriage Maker.
11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John A Chrisner
14. MOTHER'S MAIDEN NAME Susan Cadori.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Wayde Chrisner, Bel Air Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteria Sclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH
422.1
DUE TO (b) Generalized Arteriosclerosis -
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
902.7 Fracture Left Femur.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell out of Bed on Left hip - 9/21/58.
20c. TIME OF INJURY Hour 10 p. m. Month, Day, Year 9-21-1958
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing Home
20f. (City or town) Manchester (County) Carroll (State) Md

21. I certify that I attended the deceased from June 12, 1956, to October 9, 1958, that I last saw the deceased alive on October 7, 1958, and that death occurred at 5:55 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE Joseph E Bush M.D. ADDRESS (Street, city or town, state) Hampstead Md DATE SIGNED 10-9-58

PHYSICIAN'S NAME (Type) Joseph E. Bush MD Hampstead Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Oct. 11, 1958
22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Catholic
22d. LOCATION (City, town, or county) (State) Emmitsburg, Frederick Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE S. L. Allison ADDRESS Emmitsburg, Md.
24a. REC'D BY REGISTRAR DATE OCT 14 '58
24b. REGISTRAR'S SIGNATURE Arthur L. Krause

S. L. Allison

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11175

CERTIFICATE OF DEATH

11164 Reg. Dist. No.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Balto.City
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville — c. LENGTH OF STAY IN 1b: 6mos.10days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 13 3V01-4
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital	d. STREET ADDRESS: 3438 Elmora Ave. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Ida	Middle: Grace	Thompson	Lost: Davey	4. DATE OF DEATH	Month: October	Day: 7,	Year: 1958
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		8. DATE OF BIRTH: Sept. 25, 1871	9. AGE (In years last birthday): 87 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: -	11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY?: U.S.A.				
13. FATHER'S NAME: Andrew Thompson Wheeler		14. MOTHER'S MAIDEN NAME: Laura Josephine Mackheimer						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No	(If yes, give war or dates of service): -	16. SOCIAL SECURITY NO.: -	17. INFORMANT: Springfield Hospital Records	Address				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years

420.0

DUE TO

Conditions, if any, which gove rise to immediate couse (a), stating the underlying couse last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S.assoc.with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 27, 1958, to October 7, 1958, that I last saw the deceased alive an October 7, 1958, and that death accurred at 7:45P M, from the causes and an the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 10/8/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	10-10-58	Loudon Park	Baltimore

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
William Cook, Inc., 1217 St.Paul Street	OCT 10 '58	Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11176

CERTIFICATE OF DEATH

11165

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 y 6 m 6 d
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 30, Md. 3V01-4
d. STREET ADDRESS: 1520 Belt Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry; Middle: Joseph; Last: Dixon

4. DATE OF DEATH: Month: 10; Day: 4(4); Year: 19 58

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-27-90

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months; Days; Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): shipwork

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Joseph Dixon

14. MOTHER'S MAIDEN NAME: Maria Mc Nanee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: unkn

17. INFORMANT: S.S.Hospital Records
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
491X
DUE TO
(b):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: days

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
C.B.S. of unknown or unspecified cause with psych. reaction
Pulmonary tuberculosis, moderately advanced, inactive

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
002X

20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-27- 19 57, to 10-3- 19 58, that I last saw the deceased alive on 10- 3- 19 58, and that death occurred at 1:53A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 10-4-58

PHYSICIAN'S NAME (Type): Edmund Lusthaus M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/7/1958
22c. NAME OF CEMETERY OR CREMATORY: Cathedral
22d. LOCATION (City, town, or county) (State): Balto. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Flynn + Fleming, 1422 Light St.
ADDRESS:

24a. REC'D BY REGISTRAR DATE: OCT 7 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11177 **CERTIFICATE OF DEATH** Reg. Dist. No. 11166

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: 5mos.28 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ---- 11X-2
d. STREET ADDRESS: ---
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Jacob — Middle Walter — Last DOVE

4. DATE OF DEATH: Month October — Day 27 — Year 19 58

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-6-81

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal mining

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Isiah Dove

14. MOTHER'S MAIDEN NAME: Kathryn Souders

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Records of Springfield State Hospital
Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic cardiovascular disease — more than 15 yrs.
DUE TO
(c) ---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ---

20c. TIME OF INJURY: Hour — a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----

20f. (City or town) (County) (State): ---

21. I certify that I attended the deceased from April 29, 19 58, to Oct. 27, 19 58, that I last saw the deceased alive on Oct. 26, 19 58, and that death occurred at 9:50 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter Knopp M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 10-28-58.

PHYSICIAN'S NAME (Type): Walter Knopp, M. D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/30/58
22c. NAME OF CEMETERY OR CREMATORY: Fair View Cemetery
22d. LOCATION (City, town, or county) (State): Gormania, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Luther A. Hayfield
ADDRESS: Sykesville, Md.

24a. REC'D BY REGISTRAR DATE NOV 3 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11178

CERTIFICATE OF DEATH

11167

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY ~~City~~ Balto.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville

c. LENGTH OF STAY IN 1b: 2 mths 14 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 14, Md. 03X-2

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

d. STREET ADDRESS: 2914 Joppa Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah — Middle: Elizabeth — Last: Guerke

4. DATE OF DEATH: Month: 10 — Day: 5 — Year: 1958

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7- 10-67

9. AGE (In years last birthday): 91 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Joyner

14. MOTHER'S MAIDEN NAME: Amanda Flower

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: unkn

17. INFORMANT: S.S.Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: years

~~422.1~~

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. assoc.with senile brain disease with psych.reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7 - 21- 1958 to 10 - 4 - 1958, that I last saw the deceased alive on 10 - 4 - 1958, and that death occurred at 6:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 10-5-58

PHYSICIAN'S NAME (Type): Edmund Lusthaus M.D. — Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify) — 22b. DATE THEREOF: 10-8-58 — 22c. NAME OF CEMETERY OR CREMATORY: OAKLAWN — 22d. LOCATION (City, town, or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE: Leonard J Luck — ADDRESS: 5305 Harford.

24a. REC'D BY REGISTRAR DATE: OCT 7 '58 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11179

CERTIFICATE OF DEATH

Reg. Dist. No. 11168

1. PLACE OF DEATH
- a. COUNTY: CARROLL — MARYLAND
- b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL**Sykesville
- c. LENGTH OF STAY IN 1b: 2yrs
- d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
- a. STATE: Maryland
- b. COUNTY: Carroll
- c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville
- d. STREET ADDRESS: Klee Mill Rd.
- e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First DALE, Middle ALLEN, Last HAWKINS

4. DATE OF DEATH: Month OCT. Day 25, Year 1958

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-15-;1956

9. AGE (In years last birthday): 2 yrs. — IF UNDER 1 YEAR: Months 9, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: W. LeRoy Hawkins

14. MOTHER'S MAIDEN NAME: Shirley Murray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: W. LeRoy Hawkins, Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

835x

PART I. DEATH WAS CAUSED BY:
- IMMEDIATE CAUSE (a): Fractured Skull — INTERVAL BETWEEN ONSET AND DEATH: Instant
- DUE TO (b):
- DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Boy fell out of car & rt front wheel apparently ran over his head

20c. TIME OF INJURY: Hour 12:15 p.m. Month, Day, Year 10/25 1958

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Sykesville R 2 (County) Carroll (State) Md

21. I certify that I attended the deceased from 10/25, 1958, to 10/25, 1958, that I last saw the deceased alive on 10/25, 1958, and that death occurred at 12:18 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W Glenn Speicher M.D. — ADDRESS (Street, city or town, state): Westminster Md — DATE SIGNED: 10/25/58

PHYSICIAN'S NAME (Type): Acting Deputy Medical Examiner

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10-27-1958

22c. NAME OF CEMETERY OR CREMATORY: Deer Park

22d. LOCATION (City, town, or county) (State): Balto. Co. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: C. M. Waltz, ADDRESS: Winfield, Maryland

24a. REC'D BY REGISTRAR DATE OCT 27 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11163

CERTIFICATE OF DEATH

11169 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Carroll Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
c. LENGTH OF STAY IN 1b 10yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 175 E. Main St.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 Westminster
d. STREET ADDRESS 177 E. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First: FLORA Middle: ELIZABETH Last: HILTABRIDLE
4. DATE OF DEATH Month: OCT. Day: 4 Year: 1958

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: JULY 30, 1871
9. AGE (In years last birthday) 87 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home-keeper
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Carroll Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME WILLIAM HELTIBRIDLE
14. MOTHER'S MAIDEN NAME REBECCA DAYHOFF

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Address: Roy Hiltabridle Westminster, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Chronic myocarditis	Several yrs
DUE TO	Hypertension & Cerebral Hemorrhage	1950
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic Cardio	10–15 yrs
DUE TO (c)	Renal Disease Diabetes mellitus	8-10 yrs

4427 2607

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept, 1950, to Oct 4, 1958, that I last saw the deceased alive on Oct 4, 1958, and that death occurred at 1:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE OF PHYSICIAN Wilson Speicher M.D. ADDRESS (Street, city or town, state) Westminster Md DATE SIGNED 10/6/58

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Oct. 7, 1958
22c. NAME OF CEMETERY OR CREMATORY Baust Cemetery
22d. LOCATION (City, town, or county) (State) Westminster, Md

23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers Jr. ADDRESS Westminster, Md.
24a. REC'D BY REGISTRAR DATE OCT 8 58
24b. REGISTRAR'S SIGNATURE Carlton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11180

CERTIFICATE OF DEATH

Reg. Dist. No. 11170

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville,
c. LENGTH OF STAY IN 1b: 2yrs.4mos.19days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Westminster
d. STREET ADDRESS: 1 RFD #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Harry Middle Francis Last Hooper

4. DATE OF DEATH: Month October Day 7, Year 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 25, 1883

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph F. Hooper

14. MOTHER'S MAIDEN NAME: Lilly Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: 220-10-9627

17. INFORMANT: Springfield Hospital Records
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease. — INTERVAL BETWEEN ONSET AND DEATH: More than 10 yrs.
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
C.B.S.assoc.with circ.dist.,with cerebral arteriosclerosis with psychotic reaction. Left direct inguinal hernia with obstruction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 18, 1956 to October 7, 1958, that I last saw the deceased alive on October 6, 1958, and that death occurred at 8:25A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter Knopp M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 10/7/58

PHYSICIAN'S NAME (Type): Walter Knopp, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/10/58
22c. NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery
22d. LOCATION (City, town, or county) (State): Silver Run, Carroll Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Richard H Pottle
ADDRESS: Pottle Bottlestown Md

24a. REC'D BY REGISTRAR DATE OCT 9 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11181 **CERTIFICATE OF DEATH** 11171

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 371 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 47 N. West Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mentheolia; Middle: ; Last: Jones

4. DATE OF DEATH: Month: October; Day: 3; Year: 19 58

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ Separated

8. DATE OF BIRTH: 2-10-1925

9. AGE (In years last birthday): 33 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Irvin James

14. MOTHER'S MAIDEN NAME: Esther Lomax

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Mentheolia Jones — Address: 47 N. West Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Tuberculoma of the brain
010X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b): Tuberculous Meningitis
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 27, 1957, to Oct. 3, 19 58, that I last saw the deceased alive on October 3, 19 58, and that death occurred at 2:05 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: E. M. Maculans M.D.
ADDRESS (Street, city or town, state): Henryton, Maryland
DATE SIGNED: 10-3-58

PHYSICIAN'S NAME (Type): Dr. E. M. Maculans, Supt. Henryton State Hospital, Henryton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-7-58
22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill
22d. LOCATION (City, town, or county) (State): Annapolis - Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Hicks III
ADDRESS: Annapolis-Md

24a. REC'D BY REGISTRAR DATE: OCT 8 '58
24b. REGISTRAR'S SIGNATURE: C. Elton Evans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11182

CERTIFICATE OF DEATH

11172

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural-Finksburg c. LENGTH OF STAY IN 1b: 35 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X rural-- Finksburg
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS: 1 at Gamber e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: EARL	Middle: W.	Last: JORDAN	4. DATE OF DEATH	Month: OCT.	Day: 15	Year: 1958	
5. SEX: male	6. COLOR OR RACE: white	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 7-25-1902	9. AGE (In years last birthday): 56 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): shoe stitcher	10b. KIND OF BUSINESS OR INDUSTRY: shoe factory	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Walter L. Jordan		14. MOTHER'S MAIDEN NAME: Anna Elizabeth Parrish	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 213-01-9200	17. INFORMANT: Mrs. Hilda Jordan,	Address: Same

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac failure, Arteriosclerotic Heart Dis,	
DUE TO	581.0	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (b)	Emphysema, Left Lung Atlectasis,	AUG 58 to 15 OCT 58
DUE TO (c)	Cirrhosis Liver, Mild Ascites	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour a. m. p. m. Month, Day, Year 19	While at work ☐ Not while at work ☐				

21. I certify that I attended the deceased from Aug, 1958, to Oct, 1958, that I lost saw the deceased alive on 15 Oct, 1958, and that death occurred at 9:00 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard E. Hall M.D. — ADDRESS (Street, city or, town, state): Aspenville, Md. — DATE SIGNED: 15 Oct 58

PHYSICIAN'S NAME (Type): HOWARD E. HALL

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	10-19-1958	Mt. Pleasant	Gamber, Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
C. M. Waltz,	Winfield, Md.	DATE OCT 20 '58	Charles S. Mason

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11183

CERTIFICATE OF DEATH

11173
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 mo. 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Little Orleans Md
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Credy — Middle: — Last: KERLEY

4. DATE OF DEATH: Month: October — Day: 8, — Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October 12, 1878

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad worker

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Abscess of lung
521X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 5, 1958 to October 8, 1958, that I last saw the deceased alive on October 8, 1958, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 10/8/58

PHYSICIAN'S NAME (Type): Agustin delCampo, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/11/58
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.
22d. LOCATION (City, town, or county): Ritchie Hiway (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John J. Cowan & Son
ADDRESS: Ft. Collins St.

24a. REC'D BY REGISTRAR DATE: OCT 9 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraut

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11184

CERTIFICATE OF DEATH

11174
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Detour
c. LENGTH OF STAY IN 1b: 1½ years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Detour
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James Alfred Middle: Kiser Last:

4. DATE OF DEATH: Month: October Day: 6, Year: 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October 26, 1868

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Kiser

14. MOTHER'S MAIDEN NAME: Alice Rowe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Carroll Dougherty Address: Detour, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized Arteriosclerosis — 15 years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Arteriosclerotic Nephritis. Cerebral Hemorrhage

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5.21.40, 19____, to 10.6.58, 19____, that I last saw the deceased alive on 10.5.58, 19____, and that death occurred at 10:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. S. McVaugh M.D.
ADDRESS (Street, city or town, state): 49 Frederick St. Taneytown, Md.
DATE SIGNED: 10.7.58

PHYSICIAN'S NAME (Type): R.S.McVaugh M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 9, 1958
22c. NAME OF CEMETERY OR CREMATORY: Keysville Cemetery
22d. LOCATION (City, town, or county) (State): Keysville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Merwyn C. Fuss
ADDRESS: C.O.Fuss & Son, Taneytown, Maryland

24a. REC'D BY REGISTRAR DATE: OCT 9 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11185

CERTIFICATE OF DEATH

11175

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 mo. 17 days
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 115 S. Conklin Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Albert; Middle: John; Last: Kuhn

4. DATE OF DEATH: Month: October; Day: 17; Year: 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 8, 1912

9. AGE (In years last birthday): 46 yrs.

IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Kuhn

14. MOTHER'S MAIDEN NAME: Frances Schroeder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Springfield State Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: days
491X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CBS assoc. with convulsive disorder, mental deficiency without psychosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): due to epidemic encephalitis.

20c. TIME OF INJURY: Hour a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 30, 19 58 to October 17, 19 58, that I last saw the deceased alive on October 17, 19 58, and that death occurred at 9:00a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustín del Campo M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 10/17/58

PHYSICIAN'S NAME (Type): Agustin delCampo, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct 20, 1958

22c. NAME OF CEMETERY OR CREMATORY: Schwartz Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John A. Moran — ADDRESS: 3000 E. Baltimore St.

24a. REC'D BY REGISTRAR DATE: OCT 21 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11186

CERTIFICATE OF DEATH

Reg. Dist. No. 11176

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 4mos. 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1748 Abbottson St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First (Frank) Francis — Middle Joseph — Last Leikam

4. DATE OF DEATH: Month October — Day 27, — Year 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 17, 1889

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Unknown~~ Truck Helper

10b. KIND OF BUSINESS OR INDUSTRY: Gunther's Breweary -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Leikam

14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Mary (unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: 220-14-3610A

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Infarction of myocardium from coronary
DUE TO: thrombosis due to arteritis.
420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: Weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. due to arteriosclerotic heart disease. C.N.S. Syphilis.
026x

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 10, 1958, to October 27, 1958, that I last saw the deceased alive on October 27, 1958, and that death occurred at 9:27 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 10/27/58

PHYSICIAN'S NAME (Type): Agustin delCampo, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10-30-58
22c. NAME OF CEMETERY OR CREMATORY: Sacred Heart Cemetery
22d. LOCATION (City, town, or county) (State): 7401 Herman Hill Road

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: William Cook, Inc., 1217 St. Paul Street

24a. REC'D BY REGISTRAR DATE: OCT 29 '58

24b. REGISTRAR'S SIGNATURE: Clifton L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG235 10-21-58 et

11187

CERTIFICATE OF DEATH

Reg. Dist. No. 11177

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 22yr.1mo.2days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3V01-4

3. NAME OF DECEASED (Type or print): First: Luigi; Middle:; Last: Lieto

4. DATE OF DEATH: Month: October; Day: 7; Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: August 19, 1896

9. AGE (In years last birthday): 61 62 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman

10b. KIND OF BUSINESS OR INDUSTRY: Fire Co.

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unk

17. INFORMANT Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatoma — INTERVAL BETWEEN ONSET AND DEATH: years
155.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic reaction, paranoid type.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. / p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 7, 1955, to October 7, 1958, that I last saw the deceased alive on October 7, 1958, and that death occurred at 4:45p M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital, Sykesville, — DATE SIGNED

PHYSICIAN'S NAME (Type): Agustin delCampo — Maryland, 10/7/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/10/58

22c. NAME OF CEMETERY OR CREMATORY: New Cathedral

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Luther H. Haight Sykesville, Md.

24a. REC'D BY REGISTRAR DATE: OCT 14 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11188

CERTIFICATE OF DEATH

Reg. Dist. No. 11178

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural--Westminster
c. LENGTH OF STAY IN 1b: 6mo
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural--Westminster
d. STREET ADDRESS: R.D. # 6
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First MARIE Middle VIRGINIA Last MARTIN

4. DATE OF DEATH: Month Oct Day 6 Year 19 58

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: 4-11-1893

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Elgouis Doster

14. MOTHER'S MAIDEN NAME: Annie r. Gillard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: -----

17. INFORMANT: Mrs. Arthur C. Shipley, Sr. Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): A. S. C. V. Disease
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: Years

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19 58, to Oct 6, 19 58, that I last saw the deceased alive on Oct 5, 19 58, and that death occurred at 4 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James T. Marsh M.D.
ADDRESS (Street, city or town, state): 105 E MAIN St WESTMINSTER MD
DATE SIGNED: 10/6/58
PHYSICIAN'S NAME (Type): JAMES T. MARSH

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10-8-1958
22c. NAME OF CEMETERY OR CREMATORY: Harmony Grove
22d. LOCATION (City, town, or county) (State): Carroll Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. M. Waltz,
ADDRESS: Winfield, Md.

24a. REC'D BY REGISTRAR DATE: OCT 8 '58
24b. REGISTRAR'S SIGNATURE: Catherine L. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11189 **CERTIFICATE OF DEATH** 11179

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville,
c. LENGTH OF STAY IN 1b: 1m 12 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 14, Md. 3 Vol-4
d. STREET ADDRESS: 4701 Catalpha Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Laura — Middle: L. — Last: Mishenko

4. DATE OF DEATH: Month: 10 — Day: 4 — Year: 19 58

5. SEX: Fem

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan 9-12-07

9. AGE (In years last birthday): 51 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Leibold

14. MOTHER'S MAIDEN NAME: Alice Raybold

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: unkn

17. INFORMANT: S.S.Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriolar nephrosclerosis — INTERVAL BETWEEN ONSET AND DEATH: years
446x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.assoc.with cerebral arteriosclerosis,with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-22-, 1958, to 10-4-, 1958, that I last saw the deceased alive on 10-4-, 1958, and that death occurred at 8:20 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 10-4-58

PHYSICIAN'S NAME (Type): Edmund Lusthaus M.D. — Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify) — 22b. DATE THEREOF: 10-7-58 — 22c. NAME OF CEMETERY OR CREMATORY: Parkwood Cem. — 22d. LOCATION (City, town, or county): Balto — (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Leonard J. Luck — ADDRESS: 5305 Harford

24a. RECD BY REGISTRAR DATE: OCT 7 58

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

VS A15 (4)
15M 9/55

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11190 CERTIFICATE OF DEATH

11180

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY: Carroll — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Taneytown

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland COUNTY: Carroll

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Taneytown

STREET ADDRESS (If rural give location): 15 York Street

3. NAME OF DECEASED (Type or Print): (First) William (Middle) C. N. (Last) Myers

4. DATE OF DEATH: (Month) October (Day) 26, (Year) 19 58

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Widowed	March 30, 1879	79 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Labor	Farming	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jerome Myers	Sarah Jane Koontz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no		Mr. Lloyd Myers, Taneytown, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 IMMEDIATE CAUSE (A) Myocarditis Chronic — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Generalized Arteriosclerosis — 2 yrs.
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cancer Jaw (Tissue) — 1 year

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 12, 19 57, to 10/26, 19 58, that I last saw the deceased alive on Oct. 17, 19 58, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

SIGNATURE	ADDRESS (Street, city, town, state)	DATE SIGNED
E. Ambler Thompson M.D.	Taney Town md	10/27/58

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	October 29, 1958	Reformed Cemetery	Taneytown, Maryland

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
OCT 28 '58	Arthur S. Kraus	Mervyn C. Fuss C.O. Fuss & Son, Taneytown, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11191 CERTIFICATE OF DEATH

Reg. Dist. No. 11181

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr.4mos.20days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 34 03X-2
d. STREET ADDRESS: 9301 Old Harford Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ann Amanda Middle Gardiner Last Old

4. DATE OF DEATH: Month October Day 8, Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED ☒, DIVORCED ☐
8. DATE OF BIRTH: November 14, 1876
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown George I. Gardiner
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days
491X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S.assoc.with dist.of metabolism,growth or nutrition,with senile brain disease with psychotic reaction.Fracture,neck of femur,right.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 9049
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 18, 1958, to October 8, 1958, that I last saw the deceased alive on October 8, 1958, and that death occurred at 10:15P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 10/9/58
PHYSICIAN'S NAME (Type): Agustin delCampo, M.D.
Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/11/58
22c. NAME OF CEMETERY OR CREMATORY: Moreland Mem. Pk.
22d. LOCATION (City, town, or county) (State): Balto., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tickner & Sons-Balto, Md
ADDRESS:
24a. REC'D BY REGISTRAR DATE: OCT 14 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11192 **CERTIFICATE OF DEATH** Reg. Dist. No. 11182

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Westminster
c. LENGTH OF STAY IN 1b: 15 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Westminster, Md. R. D. 1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural, Westminster
d. STREET ADDRESS: Westminster, Md. R. D. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Andy — Middle: S. — Last: Osborne

4. DATE OF DEATH: Month: October — Day: 26 — Year: 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 20, 1881

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Parker, N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Melvin Osborne

14. MOTHER'S MAIDEN NAME: Martha Jane Breedlove

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-18-9199

17. INFORMANT: Mrs. Bertha Osborne — Address: Mrs. Bertha Osborne, Westminster, Md. R.D.1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Few Minutes
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary Sclerosis — 5 or 6 yrs
DUE TO
(c): Arteriosclerosis
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1955, to Oct 26, 1958, that I last saw the deceased alive on Oct 19, 1958, and that death occurred at 12:01A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wyleene Speicher M.D. — ADDRESS (Street, city or town, state): Westminster Md — DATE SIGNED: 10/27/58

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/28/58
22c. NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery
22d. LOCATION (City, town, or county) (State): Silver Run, Carroll Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Richard A. Little — ADDRESS: Littlestown, Pa.

24a. REC'D BY REGISTRAR DATE: OCT 28 '58
24b. REGISTRAR'S SIGNATURE: Esther L. Hesse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11193 **CERTIFICATE OF DEATH** 11183

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 10 mos. 14 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg 15X-2
d. STREET ADDRESS: Route #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Nettie — Middle Florence Duvall — Last PURDUM

4. DATE OF DEATH: Month October — Day 6, — Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: February 20, 1893
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Zachariah T. Duvall
14. MOTHER'S MAIDEN NAME: Marian Ward

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 577-03-6502-D
17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years

420.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 22, 1957, to October 6, 1958, that I last saw the deceased alive on October 5, 1958, and that death occurred at 4:30A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D. — ADDRESS (Street, city or town, state): Springfield Hospital — DATE SIGNED: 10/6/58

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D. — Sykesville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 8 58
22c. NAME OF CEMETERY OR CREMATORY: Wesley Grove
22d. LOCATION (City, town, or county) (State): Woodfield Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Roy W. Barber — ADDRESS: Laytonsville, Md.
24a. REC'D BY REGISTRAR — DATE: OCT 9 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VS A1S (4)
1SM 9/SS

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11184
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll 11194 MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 3yrs.10mos.20days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1538 Stonewood Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First May Middle Belle Last Lantz Reeve
4. DATE OF DEATH: Month October Day 29, Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 11, 1872
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Lantz
14. MOTHER'S MAIDEN NAME: Elizabeth Lantz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: Unk
17. INFORMANT Address: Springfield Hospital Records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — Interval between onset and death: Days
491X
DUE TO (b):
Conditions, if ony, which gave rise to immediate couse (a), stoting the underlying couse fost. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
C.B.S.assoc.with dist.of metabolism,growth or nutrition with senile brain disease with psychotic reactio n. Fracture,comminuted,right femur.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH. 9047
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Pushed to floor by another patient.

20c. TIME OF INJURY: Hour 4:45 a.m. p.m. Month, Day, Year 10/15/1958
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital
20f. (City or town) Sykesville (County) Carroll (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Naturol causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: James T. Marsh M.D.
EXAMINER'S NAME (Type): James T. Marsh, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10/30/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Interment Burial
22b. DATE THEREOF: 11-2-58
22c. NAME OF CEMETERY OR CREMATORY: Hampton
22d. LOCATION (City, town, or county) (State): Hampton, Iowa.

23. FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haight ADDRESS: Sykesville, Md.
24a. REC'D BY REGISTRAR DATE: NOV 3 '58
24b. REGISTRAR'S SIGNATURE: Clifton S. Kruse

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11195 CERTIFICATE OF DEATH

Reg. Dist. No. 11185

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) 281
a. STATE Maryland b. COUNTY Washington County

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykes ville

c. LENGTH OF STAY IN 1b one year 19 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 21032

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfiled State Hospital.

d. STREET ADDRESS 225 Winter Street.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Alvia Middle: Last: Reichard

4. DATE OF DEATH Month: OCT, 19 Day: 25 Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-4-80

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ~~Unknown~~ RETIRED ELEC. PLANT EMPLOYEE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Theodore Reichard

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ~~Unknown~~ No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: NONE

17. INFORMANT Address: Hospital records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease. — INTERVAL BETWEEN ONSET AND DEATH: years

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis — years

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain syndrome associated with arteriosclerosis and circulatory disturbances with psychotic reactions.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-18-57, 19__, to 11-25-, 1958, that I last saw the deceased alive on 11-25-, 19__, and that death occurred at 9,35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Agustin del Campo M.D. ADDRESS (Street, city or town, state) Springfield State Hospital. DATE SIGNED 11-26-58

PHYSICIAN'S NAME (Type) Agustin del Campo M.D. Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/28/58

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cem.

22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: W.J. Norkent, Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: OCT 28 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kranz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11196

CERTIFICATE OF DEATH

Reg. Dist. No. 11186

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 m 14 days

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: City ~~Balto.~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore (22), Md. 0353.2 ✓
d. STREET ADDRESS: 6743 Woodley Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

3. NAME OF DECEASED (Type or print): First: Leonard; Middle: Smith; Last: Richardson

4. DATE OF DEATH: Month: 10; Day: 19; Year: 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8 - 21 -71

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): mill worker

10b. KIND OF BUSINESS OR INDUSTRY: STEEL MFGR

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Richardson

14. MOTHER'S MAIDEN NAME: Helen Everson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE ~~unkn~~

17. INFORMANT: Springfield ~~State~~ Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: years
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. assoc. with cerebral arteriosclerosis with senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9 - 5 -, 19 58, to 10 - 19 -, 19 58, that I last saw the deceased alive on 10 - 18 - 1958, and that death occurred at 1:00 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 10-19-58

PHYSICIAN'S NAME (Type): Edmund Lusthaus M.D. — Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10/23/58
22c. NAME OF CEMETERY OR CREMATORY: UNION
22d. LOCATION (City, town, or county) (State): STEUBENVILLE — OHIO

23. FUNERAL DIRECTOR'S SIGNATURE: Walter Simpson Bradley
ADDRESS: Kendrick, Md.

24a. REC'D BY REGISTRAR DATE: OCT 21 '58

24b. REGISTRAR'S SIGNATURE: Arthur L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11197 **CERTIFICATE OF DEATH** Reg. Dist. No. 11187

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville, Md.
c. LENGTH OF STAY IN 1b: 4 y. 10 m. 3 d.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore (14) 3 W 01-4
d. STREET ADDRESS: 4700 Harford Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna; Middle: Margaret; Last: Robinson

4. DATE OF DEATH: Month: October; Day: 7; Year: 1958

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: February 6, 1873

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY?: ~~Unknown~~ U.S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Springfield State Hospital Record

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO (b): aspiration of food
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last. 416X
DUE TO (c): chronic Rheumatic Heart Disease — years

491X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1957, to October 7, 1958, that I last saw the deceased alive on October 7, 1958, and that death occurred at 1:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Rita S. Glahn, M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 10/7/58

PHYSICIAN'S NAME (Type): Rita S. Glahn, M. D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 10, 58

22c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer

22d. LOCATION (City, town, or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: H. A. Kenmann 6067 Harf. Rd

24a. REC'D BY REGISTRAR DATE: OCT 10 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Frame

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22C Film 6235 10/29/58 gg

11164

CERTIFICATE OF DEATH

11188

Reg. Dist. No.

1. PLACE OF DEATH: a. COUNTY Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
c. LENGTH OF STAY IN 1b: 3 MOS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 229 E. Main Street

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission): a. STATE Maryland — b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 [redacted] E. Westminster Md
d. STREET ADDRESS: 229 E. Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John — Middle E. — Last Sandbower Jr.

4. DATE OF DEATH: Month Oct — Day 24 — Year 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5/15/1879

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Minister

10b. KIND OF BUSINESS OR INDUSTRY: Meth. Min.

11. BIRTHPLACE (State or foreign country): Cumberland Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Sandbower

14. MOTHER'S MAIDEN NAME: Anne Le Gaurd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Son - Mr. Sandbower — Address: 229 Westminster Md. Main St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia — INTERVAL BETWEEN ONSET AND DEATH: about 1 yr.

204.4

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) — DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: White at work ☐ Not white at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 1, 19 58, to Oct 24, 19 58, that I last saw the deceased alive on Oct 24, 19 58, and that death occurred at 9:05 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Julius Chepko M.D. — ADDRESS (Street, city or town, state): 85 E. W. Green St — DATE SIGNED: 10/24/58

PHYSICIAN'S NAME (Type): Julius Chepko — Westminster Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 10/29/58 — 22c. NAME OF CEMETERY OR CREMATORY: Mt. Hope Cem. Davis Mem. Cem. — 22d. LOCATION (City, town, or county) (State): Cumberland - Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Stephens — ADDRESS: [redacted] Cumberland Md

24a. REC'D BY REGISTRAR DATE: OCT 27 '58 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11198 Items 8,9 FilmG235 11-5-58 et

CERTIFICATE OF DEATH

11189

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Carroll Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster
c. LENGTH OF STAY IN 1b 4 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster Md. R.D#2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster
d. STREET ADDRESS Westminster R.D # 2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First CHRISTINE Middle ANNA Last SCOTT

4. DATE OF DEATH Month Oct. Day 31 Year 1958

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH May 15 1877?

9. AGE (In years last birthday) 77? yrs.

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Switch board operator

10b. KIND OF BUSINESS OR INDUSTRY Hotel

11. BIRTHPLACE (State or foreign country) Morrisonville, N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Napoleon Rock

14. MOTHER'S MAIDEN NAME Mary Sorrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 216-03-9822

17. INFORMANT Address Mrs. R. L. Hahn, Westminster Md RD # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 7 hours
420.1
DUE TO (b) A.S.C.V. disease & hypertension — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 31, 1958, to Oct 31, 1958, that I last saw the deceased alive on Oct 31, 1958, and that death occurred at 10:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE James T. Marsh M.D. ADDRESS (Street, city or town, state) DATE SIGNED 11/1/58

PHYSICIAN'S NAME (Type) JAMES T. MARSH Westminster Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Nov. 4. 58

22c. NAME OF CEMETERY OR ~~CREMATORY~~ New Cathedral Cemetery

22d. LOCATION (City, town, or county) Baltimore (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers Jr. ADDRESS Westminster Md

24a. REC'D BY REGISTRAR DATE NOV 3 '58

24b. REGISTRAR'S SIGNATURE Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG235 11-5-58 et

11165

CERTIFICATE OF DEATH

Reg. Dist. No. 11190

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 54 HRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ???

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 27 Westminster
d. STREET ADDRESS: 29 E Green St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES — Middle SILAS — Last SEBOURE

4. DATE OF DEATH: Month OCT. — Day 30 — Year 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 17 1874

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): BALTIMORE MD. ?

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN - SEBOURE

14. MOTHER'S MAIDEN NAME: JULIA ANN SIXX

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): - no - (If yes, give war or dates of service): - no -

16. SOCIAL SECURITY NO.: 219-20-3621

17. INFORMANT: BROTHER — Address: WILLIAM S. SEBOURE 31 E GRANT ST WESTMINSTER.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): A.S.C.V Disease — INTERVAL BETWEEN ONSET AND DEATH: years
4221
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Apr 1957, to Oct 30 1958, that I last saw the deceased alive on Oct 30 1958, and that death occurred at 9:35 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James T. Marsh M.D. — ADDRESS (Street, city or town, state): Westminster Md — DATE SIGNED: Oct 31/58

PHYSICIAN'S NAME (Type): JAMES T MARSH

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 11 58

22c. NAME OF CEMETERY OR CREMATORY: Mountain View Cemetery

22d. LOCATION (City, town, or county) (State): Emmitsburg Frederick Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James H. Sellers — ADDRESS: 254 Main St. Westminster, Md.

24a. REC'D BY REGISTRAR DATE: NOV 3 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11199

11191

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
c. LENGTH OF STAY IN 1b 3 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission)
a. STATE Md — b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
d. STREET ADDRESS Oakland Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First SADIE Middle Last SHIPLEY

4. DATE OF DEATH Month Oct. Day 14 Year 1958

5. SEX F. — 6. COLOR OR RACE W — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH Nov. 4 1919 — 9. AGE (In years last birthday) 39 yrs. — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife — 10b. KIND OF BUSINESS OR INDUSTRY Home — 11. BIRTHPLACE (State or foreign country) Md — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ?— Stevens — 14. MOTHER'S MAIDEN NAME Anna Harvey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. 213-12-6289 — 17. INFORMANT Address Mrs. Howell Shipley Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Coma, Fracture of — INTERVAL BETWEEN ONSET AND DEATH
170X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) brain, lumbar vertebra, pelvis, Fracture — 1958
DUE TO
(c) Trauma - Carbon Accident — to 14 Oct 58

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 14 Oct 19 58 to 14 Oct 19 58, that I last saw the deceased alive on 14 Oct 19 58, and that death occurred at 12:15 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE Howard E. Hall M.D. — ADDRESS (Street, city or town, state) Sykesville, Md. — DATE SIGNED 14 Oct 58

PHYSICIAN'S NAME (Type) HOWARD E. HALL — SYKESVILLE, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 22b. DATE THEREOF 10-18-58 — 22c. NAME OF CEMETERY OR CREMATORY Bethesda — 22d. LOCATION (City, town) or county) (State) East Carroll Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE Guilford M. Haight — ADDRESS Sykesville, Md. — 24a. REC'D BY REGISTRAR DATE OCT 21 '58 — 24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11200 **CERTIFICATE OF DEATH** Reg. Dist. No. 11192

1. PLACE OF DEATH
a. COUNTY: CARROLL COUNTY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - WESTMINSTER
c. LENGTH OF STAY IN 1b: LIFE 39 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL ROUTE #6 WESTMINSTER
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First MURRAY Middle ROBERT Last STEM JR
4. DATE OF DEATH: Month OCTOBER Day 8th Year 1958

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: SEPT 11, 1919
9. AGE (In years last birthday): 39 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MURRAY ROBERT STEM SR.
14. MOTHER'S MAIDEN NAME: ETHEL ANNA TARBART

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 220-26-0364
17. INFORMANT: Address: WIFE MAY E. WANTZ STEM (SAME ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Original site - Prostate — 10 Mo.
DUE TO
(c):

177X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 31, 1957, to 10/8/58, 19____, that I last saw the deceased alive on 10/7/58, 19____, and that death occurred at 4:5A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: M. E. Robertson M.D.
ADDRESS (Street, city or town, state): New Windsor, Md.
DATE SIGNED: 10/8/58
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Oct. 11, '58
22c. NAME OF CEMETERY OR CREMATORY: TAYLORSVILLE MEM. CEM.
22d. LOCATION (City, town, or county) (State): TAYLORSVILLE MD

23. FUNERAL DIRECTOR'S SIGNATURE: James A. Sellers Jr.
ADDRESS: 254 E Main St. Westminster Md.
24a. REC'D BY REGISTRAR DATE: OCT 14 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11201 **CERTIFICATE OF DEATH** Reg. Dist. No. 11193

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Manchester
c. LENGTH OF STAY IN 1b 17 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Manchester RD #1

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Md. b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Manchester
d. STREET ADDRESS Manchester R.D #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First LIZZIE Middle BLACK Last STERNER

4. DATE OF DEATH Month Oct. Day 11 Year 1958

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH June 28 1882
9. AGE (In years last birthday) 76 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
10b. KIND OF BUSINESS OR INDUSTRY own Home
11. BIRTHPLACE (State or foreign country) Carroll Co. Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Henry Black
14. MOTHER'S MAIDEN NAME Frances Kemrod

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs Estie Sterner Address Manchester, Md R#1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH 1 year

420.1

DUE TO (b) Hypertensive Cardio-Vascular Disease — 20 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cardiac Liver Cirrhosis; Simple goiter; Direct and indirect hernia: diabetes

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 260 X
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1943, to 10-10, 1958, that I last saw the deceased alive on 10/9/, 1958, and that death occurred at 11:25 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE M. C. Porterfield M.D. ADDRESS (Street, city or town, state) Hampstead, Md. DATE SIGNED 10.13.58

PHYSICIAN'S NAME (Type) M. C. Porterfield, M.D. Hampstead, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Oct. 14 1958
22c. NAME OF CEMETERY OR CREMATORY Manchester, Md
22d. LOCATION (City, town, or county) Manchester (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE H. Keefer ADDRESS Hba Rob, Co.
24a. REC'D BY REGISTRAR DATE OCT 15 '58
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11202

CERTIFICATE OF DEATH

11194

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER RURAL
c. LENGTH OF STAY IN 1b 5 YEARS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION GLOVERS NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X UNION BRIDGE
d. STREET ADDRESS 1 BENEDUM ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First SADIE Middle ELIZABETH Last STONESIFER

4. DATE OF DEATH Month OCT Day 20 Year 1958

5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH OCT 1 - 1867
9. AGE (In years lost birthday) 91 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY OWN HOME
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME JOHN BROWN
14. MOTHER'S MAIDEN NAME MARY JANE BROWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT ROLAND STONESIFER (Sister Grabes) Address UNION BRIDGE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mutiple Cerebral Hemorrhages — INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
331X
DUE TO (b) arteriosclerosis
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Extensive decubitus ulcers
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1, 1958, to Oct 20, 1958, that I last saw the deceased alive on Oct 20, 1958, and that death occurred at 6 P. M, from the causes and on the date stated abave.

ACTUAL SIGNATURE E Reese Wilkens M.D. ADDRESS (Street, city or town, state) 15 Temperance DATE SIGNED 10/21/58

PHYSICIAN'S NAME (Type) E REESE WILKENS Westminster Md

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 10/22/58
22c. NAME OF CEMETERY OR CREMATORY LUTHERAN
22d. LOCATION (City, town, or county) TANEYTOWN (State) MD

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS D D Hartzler & Sons Union Bridge
24a. REC'D BY REGISTRAR DATE OCT 23 '58
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11203

CERTIFICATE OF DEATH

11195

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster #3
c. LENGTH OF STAY IN 1b: 74 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster #3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alonzo Middle: Irene Last: Stremmel

4. DATE OF DEATH: Month: Oct Day: 27 Year: 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/13/1958

9. AGE (In years last birthday) yrs.:

IF UNDER 1 YEAR: Months: 2 Days: 14
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Westminster Md #3

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Gerald Leroy Stremmel

14. MOTHER'S MAIDEN NAME: Viola Mae Hesley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Gerald Stremmel Address: Westminster Md #3

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Measles - Pneumonia
085.1
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: Oct 26 - bid Oct 27 -

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 13, 1958, to Oct 27, 1958, that I last saw the deceased alive on Oct 26, 1958, and that death occurred at 1:30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Virginia L. Ard M.D.
ADDRESS (Street, city or town, state): 139 Carlisle St Hanover Pa
DATE SIGNED:
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/28/58
22c. NAME OF CEMETERY OR CREMATORY: Black Rock
22d. LOCATION (City, town, or county) (State): Black Rock Pa York Co

23. FUNERAL DIRECTOR'S SIGNATURE: Frederick Bucher ADDRESS: Hanover Pa

24a. REC'D BY REGISTRAR DATE: OCT 28 '58
24b. REGISTRAR'S SIGNATURE: Arthur S. Klaus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

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Items 20&21 Film 235 11-17-58 ams Item 2 Film G235 10/29/58 gg

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11196
Reg. Dist. No.

11204 Phone call - Tom Dir. MD. 10/24/58

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2yrs. 8mos. 5days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Cambridge~~ Severn 02X-2

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital
d. STREET ADDRESS: -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Jeannette Middle Griffith Last Taylor
4. DATE OF DEATH: Month October Day 19 Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 20, 1879
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Columbus Griffith
14. MOTHER'S MAIDEN NAME: Emily Griffith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxiation due to cause other than trauma — Interval between onset and death: Minutes
DUE TO (b): Choked on Piece of cake — Minutes
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 921.7

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Involutional psychotic reaction. Pulmonary tuberculosis. 0027

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Patient choked on a piece of cake.

20c. TIME OF INJURY: Hour 4:15 a.m. p.m. Month, Day, Year: Oct 19-1958
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Springfield StateHosp.
20f. (City or town) Carroll (County) Md. (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. Glenn Speicher M.D.
EXAMINER'S NAME (Type): Dr. W. Glenn Speicher acting
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10/19/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/23/58
22c. NAME OF CEMETERY OR CREMATORY: Friendship
22d. LOCATION (City, town, or county) (State): Anne Arundel Co.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: Hopping & Kirkley, Glen Burnie, Md
24a. REC'D BY REGISTRAR DATE OCT 23 '58
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11197 Reg. Dist. No.

11205

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Westminster, Md. R. D. 2

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Westminster
d. STREET ADDRESS Westminster, Md. R. D. 2
e. IS RESIDENCE ON A FARM? YES X NO ☐

3. NAME OF DECEASED (Type or print) First Goldia Middle Belle Last Wagner
GOLDIA BELLE WAGNER

4. DATE OF DEATH Month Oct Day 12 Year 19 58

5. SEX Female
6. COLOR OR RACE White
7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH July 21, 1892
9. AGE (In years last birthday) 66 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-Housework
10b. KIND OF BUSINESS OR INDUSTRY Her own home
11. BIRTHPLACE (State or foreign country) Carroll Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Elias G. Shipley
14. MOTHER'S MAIDEN NAME Virginia Pickett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Paul W. Wagner Address Paul W. Wagner, Westminster, Md. R. D. 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — Interval between onset and death: 7 min.
DUE TO (b) Diabetes Mellitus — 7 years.
DUE TO (c)

260 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE James T. Marsh M.D.
EXAMINER'S NAME (Type) JAMES T. MARSH
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X
DATE SIGNED 10/12/58

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10/15/58
22c. NAME OF CEMETERY OR CREMATORY Zion Cemetery
22d. LOCATION (City, town, or county) (State) Nr. Westminster, Carroll Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little ADDRESS Littlestown, Pa.
24a. REC'D BY REGISTRAR DATE OCT 14 '58
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11166

CERTIFICATE OF DEATH

11198

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 27 Westminster
d. STREET ADDRESS: 141 Bishop St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First REBECCA — Middle A — Last WAGNER

4. DATE OF DEATH: Month Oct — Day 4 — Year 1958

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 10 - 1863

9. AGE (In years last birthday): 95 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elijah Leffo

14. MOTHER'S MAIDEN NAME: Elizabeth Yingling

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ns

17. INFORMANT: Address: Mrs Chas Mauchs - Westminster Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 332 x Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): arteriosclerosis unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour o. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 30, 1958 to Oct 4, 1958, that I last saw the deceased alive on Oct 2, 1958, and that death occurred at 9 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E Reese Wilkens MD — ADDRESS (Street, city or town, state): 15 Kemper av. Westminster Md — DATE SIGNED: 10/4/58

PHYSICIAN'S NAME (Type): E. REESE WILKENS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct 7-1958

22c. NAME OF CEMETERY OR CREMATORY: Wesley

22d. LOCATION (City, town, or county) (State): Carroll Co Md

23. FUNERAL DIRECTOR'S SIGNATURE: Edw C Upton — ADDRESS: Hampstead Md

24a. REC'D BY REGISTRAR DATE: OCT 8 '58

24b. REGISTRAR'S SIGNATURE: Cortland L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11206 **CERTIFICATE OF DEATH** Reg. Dist. No. 11199

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 40 y. 2 m. 2d.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown 21032
d. STREET ADDRESS: ----
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henry; Middle: Newton; Last: Wishard

4. DATE OF DEATH: Month: October; Day: 24; Year: 19 58

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: unknown

9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Wishard

14. MOTHER'S MAIDEN NAME: Rebecca Holbrenner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): - (If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerosis heart disease — INTERVAL BETWEEN ONSET AND DEATH: years
420.0
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 002X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Schizophrenic reaction, paranoid type. Pulmonary tuberculosis, far advanced, active.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/20/54, 19____, to 10/24/58, 19____, that I last saw the deceased alive on 10/24/58, 19____, and that death occurred at 3:10 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Julian Radzykewych, M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 10/24/58

PHYSICIAN'S NAME (Type): Julian Radzykewych, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 28, 1958
22c. NAME OF CEMETERY OR CREMATORY: Green Hill Cemetery
22d. LOCATION (City, town, or county): Waynesboro (State): Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: S. Marlin Boe — ADDRESS: Waynesboro, Penna.

24a. REC'D BY REGISTRAR DATE: OCT 27 '58

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH